

| Benefits at a Glance | CIGNA OAP Co-Pay Plan | | CIGNA OAP 90% Co-Insurance Plan | | CIGNA OAP 80% Co-Insurance Plan | | Kaiser Permanente |
|---|--|--|--|--|---|--|---|
| | In Network – National | Out of Network | In Network – National | Out of Network | In Network -National | Out of Network | In Network Only - Local |
| Plan Contact Number | Customer Service Number: 800-244-6224 www.cigna.com or www.mycigna.com | | | | | | Customer Service Number: 301-468-6000 www.kaiserpermanente.org |
| Primary Care Physician (PCP) | \$25 PCP co-pay; then Plan pays 100% | Plan pays 70% co-insurance after plan deductible is met | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met | Plan pays 80% co-insurance after plan deductible is met | Plan pays 60% co-insurance after plan deductible is met | \$10 PCP co-pay no charge for children up to age 5 |
| Specialty Care | \$50 Specialist co-pay; then Plan pays 100% | Plan pays 70% co-insurance after plan deductible is met | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met | Plan pays 80% co-insurance after plan deductible is met | Plan pays 60% co-insurance after plan deductible is met | \$10 PCP co-pay |
| Annual Year Deductible | \$0 | \$250 Individual \$500 Family | \$100 Individual \$200 Family | \$200 Individual \$400 Family | \$250 Individual \$500 Family | \$500 Individual \$1,000 Family | \$0 |
| Annual Out-of-Pocket Limit | \$2,000 Individual \$4,000 Family | \$4,250 Individual \$8,500 Family | \$1,500 Individual \$3,000 Family | \$3,000 Individual \$6,000 Family | \$2,000 Individual \$4,000 Family | \$4,000 Individual \$8,000 Family | \$3,500 Individual \$9,400 Family |
| Preventive Care - All Ages Routine Preventive Care Immunizations Mammogram, PAP, PSA Tests | Plan Pays 100% | Through age 17: Plan pays 70% co-insurance, no plan deductible Ages 18 and above: Plan pays 70% co-insurance after plan deductible is met | Plan Pays 100% | Through age 17: Plan pays 70% co-insurance, no plan deductible Ages 18 and above: Plan pays 70% co-insurance after plan deductible is met | Plan Pays 100% | Through age 17: Plan pays 60% co-insurance, no plan deductible Ages 18 and above: Plan pays 60% co-insurance after plan deductible is met | No charge |
| Inpatient Hospital Facility | \$200 per admission co-pay, then Plan pays 100% co-insurance | Plan pays 70% co-insurance after plan deductible is met | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met | Plan pays 80% co-insurance after plan deductible is met | Plan pays 60% co-insurance after plan deductible is met | No charge |
| Outpatient Facility Services | \$50 per facility visit co-pay, then Plan pays 100% co-insurance | Plan pays 70% co-insurance after plan deductible is met | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met | Plan pays 80% co-insurance after plan deductible is met | Plan pays 60% co-insurance after plan deductible is met | \$10 visit |
| Outpatient Professional services | Plan pays 100% co-insurance | Plan pays 70% co-insurance after plan deductible is met | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met | Plan pays 80% co-insurance after plan deductible is met | Plan pays 60% co-insurance after plan deductible is met | \$10 visit |
| Chiropractic Care | \$20 per visit co-pay; then Plan pays 100% | Plan pays 70% co-insurance after plan deductible is met. Maximum 12 visits per year | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met. Maximum 12 visits per year | Plan pays 80% co-insurance after plan deductible is met | Plan pays 60% co-insurance after plan deductible is met. Maximum 12 visits per year | \$15 co-pay; Annual limit 20 visits |
| Hearing Aids | Plan pays 100% Maximum benefit is \$2,800 every 36 months | Plan pays 100% Maximum benefit is \$2,800 every 36 months | Plan pays 90% co-insurance no deductible Maximum benefit is \$2,800 every 36 months | Plan pays 90% co-insurance no deductible Maximum benefit is \$2,800 every 36 months | Plan pays 80% co-insurance no deductible Maximum benefit is \$2,800 every 36 months | Plan pays 80% co-insurance no deductible Maximum benefit is \$2,800 every 36 months | Covered in full to maximum. One hearing aid/ear every 36 months - \$,1000 maximum |
| Vision Therapy | Plan pays 100% | Plan pays 70% co-insurance after plan deductible is met | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met | Plan pays 80% co-insurance after deductible is met | Plan pays 60% co-insurance after plan deductible is met | |
| Emergency Room | \$150 per visit (co-pay waived if admitted); then Plan pays 100% | \$150 per visit (co-pay waived if admitted); then Plan pays 100% | \$150 per visit (co-pay waived if admitted); then Plan pays 100% | \$150 per visit (co-pay waived if admitted); then Plan pays 100% | \$150 per visit (co-pay waived if admitted); then Plan pays 100% | \$150 per visit (co-pay waived if admitted); then Plan pays 100% | \$150 visit (waived if admitted other than for observation) |
| Urgent Care Facility | \$50 per visit (co-pay waived if admitted); then plan pays 100% | \$50 per visit (co-pay waived if admitted); then Plan pays 100% | \$50 per visit (co-pay waived if admitted); then Plan pays 100% | \$50 per visit (co-pay waived if admitted); then Plan pays 100% | \$50 per visit (co-pay waived if admitted); then Plan pays 100% | \$50 per visit (co-pay waived if admitted); then Plan pays 100% | \$10 visit |
| TMJ, Surgical & Non-Surgical (Physician's Office) | \$25 PCP or \$50 Specialist co-pay; then Plan pays 100% | Plan pays 70% co-insurance after plan deductible is met | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met | Not covered | Not covered | Not covered |
| Mental Health & Substance Abuse Treatment In-Patient | \$200 per admission co-pay, then Plan pays 100% co-insurance | Plan pays 70% co-insurance after plan deductible is met | Plan pays 90% co-insurance after plan deductible is met | Plan pays 70% co-insurance after plan deductible is met | Plan pays 80% co-insurance after deductible is met | Plan pays 60% co-insurance after plan deductible is met | Inpatient – covered in full when medically necessary Outpatient: \$10 Individual visit \$5 Group visit |
| Prescription Drugs for Retirees and their eligible Dependents under the age of 65 <i>Retirees over 65 and Medicare eligible: Please see insert for Cigna HealthSpring PDP information.</i> | | | | | | | Prescription Drugs |
| Annual Prescription Drug Deductible | \$50 Individual \$100 Family | | | | | | \$0 |
| Annual Prescription Drug Out-of-Pocket Limit | \$1,500 Individual \$3,000 Family | | | | | | \$0 |
| Prescription Drugs | Retail – 30 day supply \$7 co-pay - Generic 20% - Preferred - maximum \$50 30% - Non-Preferred - maximum \$100 Home delivery – 90 day supply \$0 co-pay – Generic maintenance medications; \$14 co-pay Generics non-maintenance 20% - Preferred - maximum \$100 30% - Non-Preferred - maximum \$200 | Retail You pay 30% after Pharmacy deductible Home Delivery Not Covered | Retail – 30 day supply \$7 co-pay - Generic 20% - Preferred - maximum \$50 30% - Non-Preferred - maximum \$100 Home delivery – 90 day supply \$0 co-pay – Generic maintenance medications; \$14 co-pay Generics non-maintenance 20% - Preferred - maximum \$100 30% - Non-Preferred - maximum \$200 | Retail You pay 30% after Pharmacy deductible Home Delivery Not Covered | Retail – 30 day supply \$7 co-pay - Generic 20% - Preferred - maximum \$50 30% - Non-Preferred - maximum \$100 Home delivery – 90 day supply \$0 co-pay – Generic maintenance medications; \$14 co-pay Generics non-maintenance 20%- Preferred - maximum \$100 30% - Non-Preferred - maximum \$200 | Retail You pay 30% after Pharmacy deductible Home Delivery Not Covered | Kaiser pharmacy – 30 day supply \$10 Generic \$20 Preferred drugs \$35 Non-preferred drugs Community Pharmacy \$20 Generic \$40 Preferred drugs \$55 Non-preferred drugs Mail Order – 90 day supply \$20 Generic \$40 Preferred drugs \$70 Non-preferred drugs |